

Internal Revenue bulletin

Bulletin No. 2014-4
January 21, 2014

HIGHLIGHTS OF THIS ISSUE

These synopses are intended only as aids to the reader in identifying the subject matter covered. They may not be relied upon as authoritative interpretations.

INCOME TAX

T.D. 9651, page 441.

These final regulations provide guidance on the interpretation and application of section 833(c)(5). They guide certain health care organizations in computing and applying the medical loss ratio added to the Code by the Patient Protection and Affordable Care Act.

Notice 2014-7, page 445.

This notice advises taxpayers that certain payments received by an individual care provider under a state Medicaid Home and Community-Based Services Waiver program are difficulty of care payments excludable from gross income under § 131 of the Code. The exclusion may apply whether the care provider is related or unrelated to the individual receiving care.

Announcement 2014-2, page 448.

This announcement contains one correction to I.R.B. 2014-2, which lacked certain information on the Highlights page.

ADMINISTRATIVE

Notice 2014-7, page 445.

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Finding Lists begin on page ii.
Index for July through January begins on page iv.



Department of the Treasury
Internal Revenue Service

The IRS Mission

Provide America's taxpayers top-quality service by helping them understand and meet their tax responsibilities and enforce the law with integrity and fairness to all.

Introduction

The Internal Revenue Bulletin is the authoritative instrument of the Commissioner of Internal Revenue for announcing official rulings and procedures of the Internal Revenue Service and for publishing Treasury Decisions, Executive Orders, Tax Conventions, legislation, court decisions, and other items of general interest. It is published weekly.

It is the policy of the Service to publish in the Bulletin all substantive rulings necessary to promote a uniform application of the tax laws, including all rulings that supersede, revoke, modify, or amend any of those previously published in the Bulletin. All published rulings apply retroactively unless otherwise indicated. Procedures relating solely to matters of internal management are not published; however, statements of internal practices and procedures that affect the rights and duties of taxpayers are published.

Revenue rulings represent the conclusions of the Service on the application of the law to the pivotal facts stated in the revenue ruling. In those based on positions taken in rulings to taxpayers or technical advice to Service field offices, identifying details and information of a confidential nature are deleted to prevent unwarranted invasions of privacy and to comply with statutory requirements.

Rulings and procedures reported in the Bulletin do not have the force and effect of Treasury Department Regulations, but they may be used as precedents. Unpublished rulings will not be relied on, used, or cited as precedents by Service personnel in the disposition of other cases. In applying published rulings and procedures, the effect of subsequent legislation, regulations, court decisions, rulings, and procedures must be considered, and Service personnel and others concerned are cautioned

against reaching the same conclusions in other cases unless the facts and circumstances are substantially the same.

The Bulletin is divided into four parts as follows:

Part I.—1986 Code.

This part includes rulings and decisions based on provisions of the Internal Revenue Code of 1986.

Part II.—Treaties and Tax Legislation.

This part is divided into two subparts as follows: Subpart A, Tax Conventions and Other Related Items, and Subpart B, Legislation and Related Committee Reports.

Part III.—Administrative, Procedural, and Miscellaneous.

To the extent practicable, pertinent cross references to these subjects are contained in the other Parts and Subparts. Also included in this part are Bank Secrecy Act Administrative Rulings. Bank Secrecy Act Administrative Rulings are issued by the Department of the Treasury's Office of the Assistant Secretary (Enforcement).

Part IV.—Items of General Interest.

This part includes notices of proposed rulemakings, disbarment and suspension lists, and announcements.

The last Bulletin for each month includes a cumulative index for the matters published during the preceding months. These monthly indexes are cumulated on a semiannual basis, and are published in the last Bulletin of each semiannual period.

Part I. Rulings and Decisions Under the Internal Revenue Code of 1986

Computation of, and Rules Relating to, Medical Loss Ratio

DEPARTMENT OF THE TREASURY Internal Revenue Service 26 CFR Part 1

TD 9651

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations.

SUMMARY: This document contains final regulations that provide guidance to Blue Cross and Blue Shield organizations, and certain other qualifying health care organizations, on computing and applying the medical loss ratio added to the Internal Revenue Code by the Patient Protection and Affordable Care Act.

DATES: *Effective Date:* These regulations are effective on January 7, 2014.

Applicability Date: These regulations apply to taxable years beginning after December 31, 2013.

FOR FURTHER INFORMATION CONTACT: Graham R. Green, (202) 317-6995 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

Section 833 of the Internal Revenue Code (Code) provides that Blue Cross and Blue Shield organizations, and certain other qualifying health care organizations, are entitled to: (1) treatment as stock insurance companies; (2) a special deduction under section 833(b); and (3) computation of unearned premium reserves under section 832(b)(4) based on 100 percent, and not 80 percent, of unearned premiums. This document contains final amendments to 26 CFR part 1 (Income Tax Regulations) under section 833(c)(5). Section 833(c)(5) was added to the Code by section 9016 of the Patient Protection and Affordable Care Act (Affordable Care

Act), Public Law 111-148 (124 Stat. 119 (2010)), effective for taxable years beginning after December 31, 2009. Section 833(c)(5) provides that section 833 does not apply to an organization unless the organization's medical loss ratio (MLR) for a taxable year is at least 85 percent. For purposes of section 833, an organization's MLR is its percentage of total premium revenue expended on reimbursement for clinical services provided to enrollees under its policies during such taxable year (as reported under section 2718 of the Public Health Service Act (PHSA)).

The Treasury Department and the IRS issued proposed regulations under section 833(c)(5) on May 13, 2013 (78 FR 27873). The Treasury Department and the IRS received four written comments in response to the notice of proposed rulemaking and notice of public hearing. After consideration of all comments, these final regulations adopt the provisions of the proposed regulations with certain modifications, the most significant of which are highlighted in the Summary of Comments and Explanation of Revisions. All comments are available at www.regulations.gov or upon request.

Summary of Comments and Explanation of Revisions

1. *Determining the MLR*

The proposed regulations generally provided that an organization's MLR with respect to a taxable year is the ratio, expressed as a percentage, of the MLR numerator to the MLR denominator. The MLR numerator was defined as the organization's total premium revenue expended on reimbursement for clinical services provided to enrollees under its policies for the taxable year. The MLR denominator was defined as the organization's total premium revenue for the taxable year, after excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance. The final regulations retain these definitions.

a. *MLR numerator*

The proposed regulations provided that the MLR numerator does not include amounts expended for "activities that improve health care quality." Two commenters requested that the MLR numerator include amounts expended for "activities that improve health care quality" as reported under section 2718 of the PHSA, arguing that Congress intended to include amounts expended for "activities that improve health care quality" in the MLR numerator. Two other commenters agreed with the proposed rule that amounts expended for "activities that improve health care quality" should not be included in the MLR numerator.

The final regulations retain the rule in the proposed regulations because the alternative is not supported by the statute. Section 2718 of the PHSA provides that the MLR numerator is based on both "reimbursement for clinical services provided to enrollees" and "activities that improve health care quality." By contrast, the express language of section 833(c)(5) provides that the MLR numerator is based on "reimbursement for clinical services provided to enrollees" without any reference to "activities that improve health care quality." Accordingly, the final regulations provide that the MLR numerator in section 833(c)(5) does not include costs for "activities that improve health care quality."

b. *Computation of MLR*

The proposed regulations provided that amounts used for purposes of section 833(c)(5) (that is, total premium revenue and total premium revenue expended on reimbursement for clinical services provided to enrollees) for each taxable year should be determined based on amounts reported under section 2718 of the PHSA for that taxable year and the two preceding taxable years, subject to the same adjustments that apply for purposes of section 2718 of the PHSA. In the preamble to the proposed regulations, the Treasury Department and the IRS requested com-

ments as to whether organizations should, instead of using the three-year period used for purposes of section 2718(b)(1)(B)(ii) of the PHSA, compute their expenses and total premium revenue only for the taxable year for which the computation is being made under section 833(c)(5), and whether adoption of the three-year approach would create difficulties with respect to the computation of the MLR for the 2014 taxable year.

Two commenters suggested that each organization described in section 833(c) be permitted a one-time, permanent election to compute its MLR over either the three-year period provided in the proposed regulations or over a one-year period based on the taxable year. The commenters further suggested that if a three-year period is used, transition relief should be provided to phase in the three-year period.

In describing the MLR computation under section 833(c)(5), the statute provides that the elements in the computation are to be “as reported under section 2718 of the Public Service Health Act.” The Treasury Department and the IRS have concluded that this cross reference indicates that Congress intended that, to the extent consistent with the express language of section 833(c)(5), the meaning of terms and the methodology used in the MLR computation under section 833(c)(5) should be consistent with the definition of those same terms and the methodology under section 2718 of the PHSA. Section 2718(b)(1)(B)(ii) of the PHSA and the associated regulations issued by the Department of Health and Human Services use a three-year period to compute the medical loss ratio, allowing certain limited adjustments after the end of the year to determine expenses and premium revenue. (See 45 CFR 158.220(b) and 158.140.) Accordingly, the Treasury Department and the IRS have concluded that amounts used for purposes of section 833(c)(5) for each taxable year should be determined based on amounts reported under section 2718 of the PHSA for that taxable year and the two preceding taxable years, subject to the same adjustments that apply for purposes of section 2718 of the PHSA.

In light of the comments received, the Treasury Department and the IRS have concluded that transition rules to phase in the three-year period provided in these

final regulations are appropriate. Accordingly, the final regulations provide that for the first taxable year beginning after December 31, 2013, an organization’s MLR will be computed on a one-year basis. Thus, for the first taxable year beginning after December 31, 2013, an organization’s MLR is computed based on its total premium revenue expended on reimbursement for clinical services provided to enrollees for its first taxable year beginning after December 31, 2013, and its total premium revenue for its first taxable year beginning after December 31, 2013.

For the first taxable year beginning after December 31, 2014, an organization’s MLR will be computed on a two-year basis. Thus, for the first taxable year beginning after December 31, 2014, an organization’s MLR is computed based on the sum of its total premium revenue expended on reimbursement for clinical services provided to enrollees for its first taxable year beginning after December 31, 2013, and for its first taxable year beginning after December 31, 2014, and the sum of its total premium revenue for its first taxable year beginning after December 31, 2013, and for its first taxable year beginning after December 31, 2014.

For the first taxable year beginning after December 31, 2015, and for all succeeding taxable years, the final regulations provide that the MLR is determined based on amounts reported under section 2718 of the PHSA for that taxable year and the two preceding taxable years, subject to the same adjustments that apply for purposes of section 2718 of the PHSA.

The final regulations do not adopt the commenters’ suggestion to allow organizations to make an election between the three-year period provided in the proposed regulations or the one-year period based on the taxable year. The statutory framework does not contemplate an election or provide for more than one method for computing the MLR. Further, any election would be administratively burdensome for the IRS.

2. Nonapplication of Section 833 in Case of an Insufficient MLR

The proposed regulations provided that the consequences of having an MLR of less than 85 percent (an insufficient MLR)

are as follows: (1) the organization is not taxable as a stock insurance company by reason of section 833(a)(1), but may be taxable as an insurance company if it otherwise meets the requirements of section 831(c); (2) the organization is not allowed the special deduction set forth in section 833(b); and (3) if the organization qualifies as an insurance company under section 831(c), it must take into account 80 percent, rather than 100 percent, of its unearned premiums under section 832(b)(4) as it applies to other non-life insurance companies.

In response to the proposed regulations, two commenters requested that the consequences of having an insufficient MLR under section 833(c)(5) be limited to the loss of only some of the benefits of section 833. Specifically, commenters posited that an organization that fails the MLR requirement under section 833(c)(5) should not lose its status as an insurance company under section 833(a)(1). Rather, the commenters argued that the organization should only suffer the loss of eligibility for the special deduction in section 833(b) and be subject to the less favorable computation of unearned premium reserves based on 80 percent, rather than 100 percent, of its unearned premiums under section 832(b)(4). Another commenter agreed with the proposed rule that the consequences of having an insufficient MLR under section 833(c)(5) include the loss of automatic stock insurance company status under section 833(a)(1).

Section 833(c)(5) provides that “this section [833]” shall not apply to any organization unless the organization satisfies the MLR requirement in section 833(c)(5). This language does not contemplate disallowance of some, but not all, of the benefits associated with treatment under section 833. Because the benefit of automatic stock insurance company status is provided to section 833(c) organizations in section 833(a)(1), this benefit is lost upon a failure to satisfy the MLR under section 833(c)(5). Accordingly, the Treasury Department and the IRS have concluded that for an organization described in section 833(c) that fails to satisfy the MLR requirement under section 833(c)(5): (1) the organization is not taxable as a stock insurance company by reason of section 833(a)(1), but may be

taxable as an insurance company if it otherwise meets the requirements of section 831(c); (2) the organization is not allowed the special deduction set forth in section 833(b); and (3) if the organization qualifies as an insurance company under section 831(c), it must take into account 80 percent, rather than 100 percent, of its unearned premiums under section 832(b)(4) as it applies to other non-life insurance companies.

In the proposed regulations, the Treasury Department and the IRS declined to adopt a proposal to allow an organization that would have otherwise failed to satisfy the MLR by a *de minimis* amount to pay an amount to the IRS to retain eligibility for the benefits of section 833 because the statutory framework does not contemplate a penalty or other payment to the IRS. The Treasury Department and the IRS requested comments on whether there are other possible means consistent with the statute of mitigating the consequences of having an insufficient MLR.

In response to the proposed regulations, two commenters requested that, in limited circumstances, an organization with an insufficient MLR be permitted to rebate premiums to one of the following to satisfy the section 833(c)(5) MLR requirement: (1) the Secretary of Health and Human Services; (2) policyholders; (3) a State Comprehensive Health Insurance Plan or other health related program, foundation, or guarantee fund association; or (4) a risk adjustment, reinsurance, or risk corridor program under the Affordable Care Act. Another commenter suggested that allowing any rebating of premiums to comply with section 833(c)(5) would fail to address consumers' needs for affordable coverage at the time of purchase. The Treasury Department and the IRS continue to consider whether, and, if so, how to permit organizations to address *de minimis* failures to satisfy the MLR under section 833(c)(5).

3. No Material Change

Commenters requested clarification that an organization's loss of eligibility for treatment under section 833 by reason of section 833(c)(5) will not be treated as a material change in the operations of such organization or in its structure for purposes of section 833(c)(2)(C). Section

833(c) restricts the application of section 833 to any existing Blue Cross or Blue Shield organization, and any other qualifying organization meeting the requirements of section 833(c)(3). Section 833(c)(2)(C) defines the term "existing Blue Cross or Blue Shield organization" to mean any Blue Cross or Blue Shield organization if such organization was in existence on August 16, 1986, such organization was determined to be exempt from tax for its last taxable year beginning before January 1, 1987, and no material change has occurred in the operations of such organization or in its structure after August 16, 1986, and before the close of its current taxable year.

The final regulations adopt this suggestion. Consistent with the annual determination of whether an organization's MLR under section 833(c)(5) is at least 85 percent, which allows eligibility for treatment under section 833 to be recovered if lost by reason of section 833(c)(5), the Treasury Department and the IRS have concluded that a change in an organization's eligibility for treatment under section 833 solely by reason of section 833(c)(5) will not be treated as a material change in the operations of such organization or in its structure for purposes of section 833(c)(2)(C).

4. Accounting for Unearned Premiums

In Notice 2011-4 (2011-2 I.R.B. 282 (December 29, 2010)) and Rev. Proc. 2011-14 (2011-4 I.R.B. 330 (January 11, 2011)) (both of which are available at www.irs.gov), the Treasury Department and the IRS provided procedures for an organization to obtain automatic consent to change its method of accounting for unearned premiums because of the application of section 833(c)(5). Two commenters raised questions about the continued application of Notice 2011-4. The guidance provided in Notice 2011-4 and Rev. Proc. 2011-14 continues to apply in its current form and is not superseded by these final regulations. See § 601.601(d)(2)(ii)(b).

Applicability Date

These regulations apply to taxable years beginning after December 31, 2013.

Special Analyses

It has been determined that this Treasury decision is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required. It also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations and because the regulations do not impose an information collection on small entities, the Regulatory Flexibility Act (5 U.S.C. chapter 6) does not apply. Pursuant to section 7805(f) of the Code, the proposed regulations preceding these regulations were submitted to the Chief Counsel for Advocacy of the Small Business Administration for comments on its impact on small business. No comments were received.

Drafting Information

The principal author of these regulations is Graham R. Green, Office of Associate Chief Counsel (Financial Institutions & Products). However, other personnel from the Treasury Department and the IRS participated in their development.

List of Subjects in 26 CFR Part 1

Income taxes, Reporting and record-keeping requirements.

Adoption of Amendments to the Regulations

Accordingly, 26 CFR part 1 is amended as follows:

PART 1—INCOME TAXES

Paragraph 1. The authority citation for part 1 continues to read in part as follows:

Authority: 26 U.S.C. 7805 * * *

Par. 2. Section 1.833-1 is added to read as follows:

§ 1.833-1 *Medical Loss Ratio Under Section 833(c)(5)*.

(a) *In general.* Section 833 does not apply to an organization unless the organization's medical loss ratio (MLR) for a taxable year is at least 85 percent. Paragraph (b) of this section provides defini-

tions that apply for purposes of section 833(c)(5) and this section. Paragraph (c) of this section provides rules for computing an organization's MLR under section 833(c)(5). Paragraph (d) of this section addresses the treatment under section 833 of an organization that has an MLR of less than 85 percent. Paragraph (e) of this section provides the effective/applicability date.

(b) *Definitions.* The following definitions apply for purposes of section 833(c)(5) and this section.

(1) *Reimbursement for clinical services provided to enrollees.* The term *reimbursement for clinical services provided to enrollees* has the same meaning as that term has in section 300gg-18 of title 42, United States Code and the regulations issued under that section (see 45 CFR 158.140).

(2) *Total premium revenue.* The term *total premium revenue* means the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act, Public Law 111-148 (124 Stat. 119 (2010)) (42 U.S.C. sections 18061, 18062, and 18063)) as those terms are used for purposes of section 300gg-18(b) of title 42, United States Code and the regulations issued under that section (see 45 CFR Part 158).

(c) *Computation of MLR under section 833(c)(5)—(1) In general.* Starting with the first taxable year beginning after December 31, 2015, and for all succeeding taxable years, an organization's MLR with respect to a taxable year is the ratio, expressed as a percentage, of the MLR numerator, as described in paragraph (c)(1)(i) of this section, to the MLR denominator, as described in paragraph (c)(1)(ii) of this section.

(i) *MLR numerator.* The numerator of an organization's MLR is the total premium revenue expended on reimbursement for clinical services provided to en-

rollees under its policies for the taxable year, computed using a three-year period in the same manner as those expenses are computed for the plan year for purposes of section 300gg-18(b) of title 42, United States Code and regulations issued under that section (see 45 CFR Part 158).

(ii) *MLR denominator.* The denominator of an organization's MLR is the organization's total premium revenue for the taxable year, computed using a three-year period in the same manner as the total premium revenue is computed for the plan year for purposes of section 300gg-18(b) of title 42, United States Code and regulations issued under that section (see 45 CFR Part 158).

(2) *Transition rules.* The transition rules in paragraphs (c)(2)(i) and (c)(2)(ii) of this section apply solely for the first taxable year beginning after December 31, 2013, and the first taxable year beginning after December 31, 2014.

(i) *First taxable year beginning after December 31, 2013.* For the first taxable year beginning after December 31, 2013, the numerator of an organization's MLR is the total premium revenue expended on reimbursement for clinical services provided to enrollees under its policies for the first taxable year beginning after December 31, 2013, and the denominator of an organization's MLR is the organization's total premium revenue for the first taxable year beginning after December 31, 2013.

(ii) *First taxable year beginning after December 31, 2014.* For the first taxable year beginning after December 31, 2014, the numerator of an organization's MLR is the sum of the total premium revenue expended on reimbursement for clinical services provided to enrollees under its policies for the first taxable year beginning after December 31, 2013, and for the first taxable year beginning after December 31, 2014, and the denominator of an organization's MLR is the sum of the organization's total premium revenue for the first taxable year beginning after December 31, 2013, and for the first taxable year beginning after December 31, 2014.

(d) *Failure to qualify under section 833(c)(5)—(1) In general.* If, for any taxable year, an organization's MLR is less than 85 percent, then beginning in that taxable year and for each subsequent taxable year for which the organization's MLR remains less than 85 percent, paragraphs (d)(1)(i) through (d)(1)(iii) of this section apply.

(i) *Automatic stock insurance company status.* The organization is not taxable as a stock insurance company by reason of section 833(a)(1), but may be taxable as an insurance company if it otherwise meets the requirements of section 831(c);

(ii) *Special deduction.* The organization is not allowed the special deduction set forth in section 833(b); and

(iii) *Premiums earned.* The organization must take into account 80 percent, rather than 100 percent, of its unearned premiums under section 832(b)(4) as it applies to other non-life insurance companies, provided the organization qualifies as an insurance company by meeting the requirements of section 831(c).

(2) *No material change.* An organization's loss of eligibility for treatment under section 833 solely by reason of section 833(c)(5) will not be treated as a material change in the operations of such organization or in its structure for purposes of section 833(c)(2)(C).

(e) *Effective/applicability date.* This section applies to taxable years beginning after December 31, 2013.

John Dalrymple,
Deputy Commissioner for
Services and Enforcement.

Approved January 2, 2014

Mark J. Mazur,
Assistant Secretary of the Treasury
(Tax Policy).

(Filed in the Office of the Federal Register on January 6, 2014, 8:45 A.M., and published in the issue of the Federal Register for January 7, 2014, 79 F.R. 755)

Part III. Administrative, Procedural, and Miscellaneous

Foster care payment, Medicaid waivers

Notice 2014-7

PURPOSE

This notice provides that certain payments received by an individual care provider under a state Medicaid Home and Community-Based Services Waiver (Medicaid waiver) program, described in this notice, are difficulty of care payments excludable under § 131 of the Internal Revenue Code.

BACKGROUND

Qualified foster care payments

Section 131(a) excludes qualified foster care payments from the gross income of a foster care provider.

Section 131(b)(1) defines a qualified foster care payment, in part, as any payment under a foster care program of a state or a political subdivision that is either (1) paid to the foster care provider for caring for a qualified foster individual in the foster care provider's home, or (2) a difficulty of care payment.

Section 131(b)(2) defines a qualified foster individual as any individual who is living in a foster family home in which the individual was placed by an agency of a state or political subdivision or by a qualified foster care placement agency.

Section 131(b)(3) defines a qualified foster care placement agency, in part, as a placement agency that is licensed or certified for the foster care program of a state or political subdivision of a state.

Section 131(c) defines a difficulty of care payment as compensation to a foster care provider for the additional care required because the qualified foster individual has a physical, mental, or emotional handicap. The provider must provide the care in the provider's foster family home, a state must determine the need for this compensation, and the payor must designate the compensation for this purpose. In the case of any foster home, difficulty of care payments are not excludable to the extent that the payments are for more than 10 qualified foster individuals

who have not attained age 19 or 5 qualified foster individuals who have attained age 19. See § 131(c)(2).

State Medicaid waiver programs

Under § 1915(c) of the Social Security Act (42 U.S.C. § 1396n(c)), a state may obtain a Medicaid waiver that allows the state to include in the state's Medicaid program the cost of home or community-based services (other than room and board) provided to individuals who otherwise would require care in a hospital, nursing facility, or intermediate care facility (eligible individuals). Home or community-based services include personal care services, habilitation services, and other services that are "cost effective and necessary to avoid institutionalization." See 42 C.F.R. § 440.180. Personal care services are defined under rules of the Centers for Medicare and Medicaid Services to include assistance with eating, bathing, dressing, toileting, transferring, maintaining continence, personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management. Skilled services that only a health professional may perform are not personal care services. Habilitation services, defined in 42 U.S.C. § 1396n(c)(5)(A), assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

Medicaid waiver programs generally do not compensate a family member for providing personal care services to an eligible individual if the family member is legally responsible for the individual (for example, a minor child). See 42 C.F.R. § 440.167(a)(2) and (b). Some states compensate family members, as well as unrelated individual care providers, for residential habilitation, foster/companion care, or transportation services provided as a part of an eligible individual's plan of care. A plan of care is a term defined by the state, but generally means an individualized plan of treatment, services, and/or providers.

A state, directly or indirectly through an agency under contract with the state, certifies individuals and entities as Medicaid providers to provide services to eligible individuals. An entity that is a certified Medicaid provider may contract with an individual care provider to care for an eligible individual in the care provider's home. A state or an agency under contract with the state approves the plan of care for the eligible individual in the provider's home and monitors the eligible individual's care.

State agencies, certified Medicaid provider entities, and individual care providers have asked whether Medicaid waiver payments for the care of eligible individuals, who are related or unrelated to the individual care provider, in the individual care provider's home may be treated as difficulty of care payments excludable under § 131.

Current treatment of government-funded payments for home care

The Service historically has challenged the excludability of payments to individual care providers caring for related individuals in the provider's home. See *Alexander v. Commissioner*, T.C. Summary Opinion 2011-48, filed April 12, 2011 (Medicaid waiver payments to taxpayers caring for a taxpayer's parents residing in the taxpayers' home are not excludable under § 131 because the taxpayers did not show that they operated a "foster family home" under state law and the parents were not "placed" in the taxpayers' home by the state). See also *Bannon v. Commissioner*, 99 T.C. 59 (1992) (payments received by the taxpayer for caring for her adult disabled daughter residing in the taxpayer's home under a state program for in-home supportive services are not excludable under the general welfare exclusion) and *Harper v. Commissioner*, T.C. Summary Opinion 2011-56, filed May 2, 2011 (following *Bannon*). Similarly, Program Manager Technical Advice (PMTA 2010-007) concludes that a biological parent of a disabled child may not exclude payments under § 131 because the ordinary meaning of foster care excludes care by a biological parent.

Section 131 does not explicitly address whether payments under Medicaid waiver programs are qualified foster care payments. Medicaid waiver programs and state foster care programs, however, share similar oversight and purposes. The purpose of Medicaid waiver programs and the legislative history of § 131 reflect the fact that home care programs prevent the institutionalization of individuals with physical, mental, or emotional handicaps. See 128 Cong. Rec. 26905 (1982) (stating that “[difficulty of care payments] are not income to the [foster] parents, regardless of whether they, dollar for dollar only cover expenses. [These] parents are saving the taxpayers’ money by preventing institutionalization of these children.”); S. Rep. No. 97-139 at 481 (1981) (describing the purpose of the amendment to 42 U.S.C. section 1396n, allowing Medicaid waivers for home and community-based services, as “[permitting] the Secretary to waive the current definition of covered [M]edicaid services to include certain nonmedical support services, other than room and board, which are provided pursuant to a plan of care to an individual otherwise at risk of being institutionalized and who would, in the absence of such services be institutionalized”). Both programs require state approval and oversight of the care of the individual in the provider’s home. The programs share the objective of enabling individuals who otherwise would be institutionalized to live in a family home setting rather than in an institution, and both difficulty of care payments and Medicaid waiver payments compensate for the additional care required.

GUIDANCE

Treatment of qualified Medicaid waiver payments under § 131

To achieve consistent federal tax treatment of Medicaid waiver payments among the states and individual care providers, this notice provides that as of January 3, 2014, the Service will treat qualified Medicaid waiver payments as difficulty of care payments under § 131(c) that are excludable under § 131, and this treatment will apply whether the care provider is related or unrelated to the eligible individual. Accordingly, as of January 3,

2014, the Service will no longer assert the position in PMTA 2010-007, or apply *Alexander*, *Bannon*, or *Harper*, to conclude that a caregiver of a biological relative receiving qualified Medicaid waiver payments may not qualify as a foster care provider under § 131. For purposes of this notice, qualified Medicaid waiver payments are payments made by a state or political subdivision thereof, or an entity that is a certified Medicaid provider, under a Medicaid waiver program to an individual care provider for nonmedical support services provided under a plan of care to an eligible individual (whether related or unrelated) living in the individual care provider’s home.

Section 131(c) defines a difficulty of care payment as compensation to a foster care provider for the additional care required because the qualified foster individual has a physical, mental, or emotional handicap. Qualified Medicaid waiver payments compensate a care provider for providing the additional care required because of an eligible individual’s physical, mental, or emotional handicap for which a state has determined that there is a need for additional compensation. Thus, the treatment of qualified Medicaid waiver payments as “difficulty of care payments” is consistent with the definition under § 131(c).

Under § 131, payments are excludable as difficulty of care payments only if the care is provided to a “qualified foster individual,” meaning any individual who is living in a “foster family home” in which the individual was “placed” by an agency of a state or a political subdivision thereof, or a qualified foster care placement agency. Section 131(b)(2). The term “foster family home” is not defined under § 131. However, the Tax Court has concluded that, for purposes of § 131, “a person’s ‘home’ is where he resides.” See *Stromme v. Commissioner*, 138 T.C. 213, 218 (2012), citing *Dobra v. Commissioner*, 111 T.C. 339 (1998). Therefore, an eligible individual receiving care under a Medicaid waiver program lives in a “foster family home” because the eligible individual is a qualified “foster” individual who receives care in a “family home” setting, as opposed to an institution, where the individual care provider also resides. Medicaid waiver payments made to a pro-

vider for care outside of the home where the provider resides are not qualified Medicaid waiver payments and are not excludable under § 131.

Similarly, the term “placed” is not defined in § 131. Under state foster care programs, a state or political subdivision thereof, or a qualified foster care placement agency, may assist in locating a home that meets the qualified foster individual’s needs, negotiate or approve the foster care payment rates, and contract with the foster care providers for the provision of foster care. The Tax Court has determined that these activities constitute “placement” for purposes of § 131(b)(2). *Micorescu v. Commissioner*, T.C. Memo 1998-398. States perform similar activities with respect to individuals participating in Medicaid waiver programs. Under a Medicaid waiver program, a state, an agency of a state or political subdivision thereof, or a certified Medicaid provider may assist in locating a home for an eligible individual or approve the eligible individual’s choice to reside in the individual care provider’s home, approve an eligible individual’s plan of care, assess the suitability of the home for fulfilling the eligible individual’s plan of care, and enter into a contract or other arrangement with the individual care provider for services provided to the eligible individual. Thus, an eligible individual receiving care in the home of the individual care provider under the Medicaid waiver program will be treated as “placed” by an agency of a state or political subdivision thereof, or a qualified foster care placement agency, for purposes of § 131. Accordingly, an eligible individual receiving care in the individual care provider’s home under a Medicaid waiver program is a “qualified foster individual” under § 131(b)(2).

Section 131(d)(2) provides that a provider may not exclude payments for the care of more than 10 eligible individuals under age 19 or more than five eligible individuals who are age 19 or over. Because qualified Medicaid waiver payments are difficulty of care payments, they are subject to these limits.

This notice does not address whether qualified Medicaid waiver payments excluded from income under this notice may be subject to tax under the Federal Insurance Contributions Act (FICA) or the

Federal Unemployment Tax Act (FUTA) in certain circumstances.

EFFECTIVE DATE

This notice is effective for payments received on or after January 3, 2014. Taxpayers may apply this notice in taxable

years for which the period of limitation on claims for a credit or refund under § 6511 has not expired.

DRAFTING INFORMATION

The principal author of this notice is Victoria J. Driscoll of the Office of Asso-

ciate Chief Counsel (Income Tax & Accounting). For further information regarding this notice, contact Ms. Driscoll at (202) 317-4718 (not a toll-free number).

Part IV. Items of General Interest

Correction to the Highlights and correction to Rev. Proc. number in IRB 2014–2

Announcement 2014–2, page 448.

This announcement contains one correction to I.R.B. 2014–2, which lacked certain information on the Highlights page.

On the Highlights page, the synopsis paragraph for Rev. Proc. 2014–14 should have appeared. The following is what should have appeared.

Rev. Proc. 2014–14, page 295.

This revenue procedure provides issuers of qualified mortgage bonds, as defined in § 143(a) of the Code, and issuers of mortgage credit certificates, as defined

in § 25(c), with a list of qualified census tracts for each state and the District of Columbia.

See §§ 25(c)(2)(A)(iii)(V) and 143(j)(1)(A). Rev. Proc. 2003–49 is modified and superseded.

The electronic copy of I.R.B. 2014–2 was corrected and reposted on the IRS' website at www.irs.gov.

Definition of Terms

Revenue rulings and revenue procedures (hereinafter referred to as “rulings”) that have an effect on previous rulings use the following defined terms to describe the effect:

Amplified describes a situation where no change is being made in a prior published position, but the prior position is being extended to apply to a variation of the fact situation set forth therein. Thus, if an earlier ruling held that a principle applied to A, and the new ruling holds that the same principle also applies to B, the earlier ruling is amplified. (Compare with modified, below).

Clarified is used in those instances where the language in a prior ruling is being made clear because the language has caused, or may cause, some confusion. It is not used where a position in a prior ruling is being changed.

Distinguished describes a situation where a ruling mentions a previously published ruling and points out an essential difference between them.

Modified is used where the substance of a previously published position is being changed. Thus, if a prior ruling held that a principle applied to A but not to B, and the new ruling holds that it applies to both A

and B, the prior ruling is modified because it corrects a published position. (Compare with amplified and *clarified*, above).

Obsoleted describes a previously published ruling that is not considered determinative with respect to future transactions. This term is most commonly used in a ruling that lists previously published rulings that are obsoleted because of changes in laws or regulations. A ruling may also be obsoleted because the substance has been included in regulations subsequently adopted.

Revoked describes situations where the position in the previously published ruling is not correct and the correct position is being stated in a new ruling.

Superseded describes a situation where the new ruling does nothing more than restate the substance and situation of a previously published ruling (or rulings). Thus, the term is used to republish under the 1986 Code and regulations the same position published under the 1939 Code and regulations. The term is also used when it is desired to republish in a single ruling a series of situations, names, etc., that were previously published over a period of time in separate rulings. If the new ruling does more than restate the sub-

stance of a prior ruling, a combination of terms is used. For example, modified and *superseded* describes a situation where the substance of a previously published ruling is being changed in part and is continued without change in part and it is desired to restate the valid portion of the previously published ruling in a new ruling that is self contained. In this case, the previously published ruling is first modified and then, as modified, is superseded.

Supplemented is used in situations in which a list, such as a list of the names of countries, is published in a ruling and that list is expanded by adding further names in subsequent rulings. After the original ruling has been supplemented several times, a new ruling may be published that includes the list in the original ruling and the additions, and supersedes all prior rulings in the series.

Suspended is used in rare situations to show that the previous published rulings will not be applied pending some future action such as the issuance of new or amended regulations, the outcome of cases in litigation, or the outcome of a Service study.

Abbreviations

The following abbreviations in current use and formerly used will appear in material published in the Bulletin.

A—Individual.
Acq.—Acquiescence.
B—Individual.
BE—Beneficiary.
BK—Bank.
B.T.A.—Board of Tax Appeals.
C—Individual.
C.B.—Cumulative Bulletin.
CFR—Code of Federal Regulations.
CI—City.
COOP—Cooperative.
Ct.D.—Court Decision.
CY—County.
D—Decedent.
DC—Dummy Corporation.
DE—Donee.
Del. Order—Delegation Order.
DISC—Domestic International Sales Corporation.
DR—Donor.
E—Estate.
EE—Employee.
E.O.—Executive Order.
ER—Employer.

ERISA—Employee Retirement Income Security Act.
EX—Executor.
F—Fiduciary.
FC—Foreign Country.
FICA—Federal Insurance Contributions Act.
FISC—Foreign International Sales Company.
FPH—Foreign Personal Holding Company.
F.R.—Federal Register.
FUTA—Federal Unemployment Tax Act.
FX—Foreign corporation.
G.C.M.—Chief Counsel’s Memorandum.
GE—Grantee.
GP—General Partner.
GR—Grantor.
IC—Insurance Company.
I.R.B.—Internal Revenue Bulletin.
LE—Lessee.
LP—Limited Partner.
LR—Lessor.
M—Minor.
Nonacq.—Nonacquiescence.
O—Organization.
P—Parent Corporation.
PHC—Personal Holding Company.
PO—Possession of the U.S.
PR—Partner.
PRS—Partnership.

PTE—Prohibited Transaction Exemption.
Pub. L.—Public Law.
REIT—Real Estate Investment Trust.
Rev. Proc.—Revenue Procedure.
Rev. Rul.—Revenue Ruling.
S—Subsidiary.
S.P.R.—Statement of Procedural Rules.
Stat.—Statutes at Large.
T—Target Corporation.
T.C.—Tax Court.
T.D.—Treasury Decision.
TFE—Transferee.
TFR—Transferor.
T.I.R.—Technical Information Release.
TP—Taxpayer.
TR—Trust.
TT—Trustee.
U.S.C.—United States Code.
X—Corporation.
Y—Corporation.
Z—Corporation.

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Key to Abbreviations:

| | |
|-----|----------------------------------|
| Ann | Announcement |
| CD | Court Decision |
| DO | Delegation Order |
| EO | Executive Order |
| PL | Public Law |
| PTE | Prohibited Transaction Exemption |
| RP | Revenue Procedure |
| RR | Revenue Ruling |
| SPR | Statement of Procedural Rules |
| TC | Tax Convention |
| TD | Treasury Decision |
| TDO | Treasury Department Order |

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